DECLARATION AND REQUEST FOR REPLACEMENT LICENSE

Return this completed form and the old license (if you still have it), with a check or Money Order for the application fee of $25 for each license requested, (payable to NHAP) to the following address:

Nursing Home Administrator Program
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416

PRINT OR TYPE

APPLICANT'S NAME *(Last)* *(First)* *(M.I.)*	SOCIAL SECURITY NUMBER *
MAILING ADDRESS *(Number)* *(Street)*	WORK TELEPHONE NUMBER ( )
ADDRESS FOR PUBLIC RECORD (Number) (Street) (City) (State) (Country) (Zip Code)	
(City) *(County)* *(State)* *(Zip Code)*	HOME TELEPHONE NUMBER ( )
E-MAIL ADDRESS / LICENSE NUMBER	DATE OF BIRTH

*Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code section 17520, subdivision (d), the Department of Health Services (DHS) is required to collect social security numbers from all applicants for nursing home administrator licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Department of Child Support Services and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 *et seq.* Failure to provide your social security number will result in the return of your application. Your social security number will be used by DHS for internal identification, and may be used to verify information on your application, to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.

REQUEST IS MADE FOR:

- ☐ Replacement NHA Wall Certificate
- ☐ Replacement C.E. Provider Wall Certificate
- ☐ Replacement Preceptor Wall Certificate
- ☐ Replacement C.E. Provider Certificate

REASON FOR REQUEST:

- ☐ Lost
- ☐ Name Change **(Affidavit Needed)**
- ☐ Original License or Certificate Not Received (No Fee If Within 2 Months)
- ☐ Original License or Certificate Not Printed Correctly (No Fee Required)
- ☐ Address Change
- ☐ Status Change
- ☐ Stolen
- ☐ Active
- ☐ Mutilated
- ☐ Inactive
- ☐ Destroyed

**** CERTIFICATION—IMPORTANT—PLEASE READ BEFORE SIGNING—If not signed, this application may be rejected. ****

I certify under penalty of the perjury laws of the State of California that the information I have entered on this application is true and correct to the best of my knowledge. I further understand that any false, incomplete, or incorrect statements may result in denial of this replacement license application by the Nursing Home Administrator Program(NHAP). I fully understand that NHAP may require additional documentation prior to approving and issuing a duplicate license.

APPLICANT'S SIGNATURE **	DATE SIGNED **
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APPLICANTS—DO NOT USE THE SPACE BELOW—FOR NHAP USE ONLY

CASH. # _____	STATUS ☐ Approved ☐ Rejected ☐ Denied	
NHAP INITIALS _____	☐ Missing Information	☐ Fee
AMOUNT _____	☐ Name Change Affidavit	
	STAFF	DATE PROCESSED